Travel insurance terms and conditions
Valid from 01.01.2019

These insurance terms and conditions define the scope of coverage and conditions in the travel insurance contract concluded between the insurer and the policyholder. The contractual rights and obligations set out in this document apply to both the policyholder and those considered equivalent to them.

1. Definitions

1.1. **The insurer** is Elama Kindlustus AS.

1.2. **The policyholder** is the person who has entered into an insurance contract with the insure.

1.3. **The insured person** is the resident of Estonia listed on the policy, whose associated insurance risk is covered.

1.4. **Policy** is an offer to enter into an insurance contract on the terms specified in the policy until the contract comes into effect. After the payment of the insurance premium and the contract coming into effect, the policy serves as a document verifying the insurance contract on the conditions specified in the policy.

1.5. **Beneficiary** is a person entitled to receive an insurance indemnity in the event of an insured event. In these conditions, the beneficiary is the policyholder unless otherwise agreed.

1.6. **The insurance period** is the agreed timeframe indicated on the policy during which the insurance contract is valid.

1.7. The validity area is the territory indicated on the policy where the insured person lawfully resides and where the insurance contract is valid.

1.8. **Trip** refers to the temporary stay of the insured person abroad, lasting no longer than one year.

1.9. **Insurance risk** is the hazard against which insurance is taken. In these terms, the insurance risk is the possibility of the insured person falling ill, their illness worsening, being involved in an accident, or death.

1.10. **Increase of insurance risk** occurs when, due to changes after the contract is concluded, the likelihood of an insured event or potential damage increases.

1.11. **Insured event** is a sudden, unexpected event, beyond the control of the insured person, which occurs during the insurance period and is defined in these terms. As a result, the insured person or a third party gains the right to claim an insurance indemnity, and the insurer is obliged to pay it.

1.12. **Sum insured** is the maximum compensation amount for each insured person, as stated in the insurance contract.

1.13. **Insurance indemnity** is the sum paid to cover losses and expenses arising from an insured event.

1.14. **Insurance premium** is the fee determined by the insurer that the policyholder must pay for the insurance.

1.15. **Double insurance** occurs when the same insurance risk is insured with multiple insurers, and the total insurance indemnity paid by the insurers exceeds the actual amount of the damage.

2. Insurance contract

2.1. The insurance contract is an agreement, in a form that can be reproduced in writing, between the insurer and the policyholder. Under this contract, the policyholder is obliged to pay the insurance premium and fulfill other obligations, while the insurer is obliged to pay the insurance indemnity or part thereof in the event of an insured event and fulfill other obligations arising from the contract.

2.2. The insurance contract consists of the policy and these terms and conditions.

2.3. The insurance contract comes into force when the insurance premium, or the first part of it, has been fully paid, but not before the first day of the insurance period. There is no retroactive insurance coverage, and the contract is not in effect before the insurance premium is received.

2.4. In matters not regulated by these terms and conditions or the policy, the parties to the insurance contract shall follow the laws of the Republic of Estonia.

2.5. By paying the insurance premium, the policyholder confirms they have read the terms and conditions and informed the insured person of them before concluding the contract.

2.6. The insurer has the right to refuse to enter into an insurance contract.

2.7. The insurance contract is concluded for a duration of one day to one year.

2.8. The insurer's liability is limited to the number of days specified on the policy, even if the insurance period is longer than the number of days covered.

2.9. The insurance contract is valid within the geographical area indicated on the policy where the insured person resides during the trip.

2.10. The contract ends at 24:00 on the last day of the insurance period indicated on the policy, by mutual agreement, or in other cases specified by law or in the insurance contract.

2.11. Before the start of the insurance period, the policyholder has the right to withdraw from the contract by submitting a written request, along with the policy and proof of identity, to the insurer. In the case of withdrawal, 10% of the insurance premium will be deducted to cover administrative and contract-related costs. The excess paid premium, minus these costs, will be refunded to the policyholder.

2.12. The insurer has the right to terminate the contract if the terms outlined in sections 3.1.1 - 3.1.4 are violated, by notifying the policyholder in writing.

2.13. If the insurance contract ends early due to cancellation, withdrawal, or other reasons, the insurer has the right to withhold 25% of the insurance premium as administrative costs.

2.14. The insurer and the policyholder have the right to terminate the contract after an insured event, giving one week's notice in writing to the other party. In this case, the insurer is still obliged to fulfill the contract regarding any insured events that occurred during the validity period.

3. Rights and Obligations of the Parties

3.1. The policyholder and the insured person are obligated to:

3.1.1. Inform the insurer at the time of entering into the insurance contract of all circumstances known to them that may influence the insurer's decision to enter into the insurance contract;

3.1.2. Pay the insurance premium in full by the deadline set by the insurer;

3.1.3. Inform the insurer during the validity period of the insurance contract of any increase in the insurance risk. The obligation to notify must be fulfilled within a reasonable time after becoming aware of the increase in risk, by sending a written notice in a reproducible format;

3.1.4. Do everything within their power to prevent the occurrence of an insured event and reduce potential damage, and not to increase the insurance risk or allow a third party to do so;

3.1.5. Immediately inform the insurer in a reproducible written format about the occurrence of multiple insurance policies.

3.2. The policyholder has the right to request the issuance of a replacement policy in the event of loss or destruction of the original policy, as well as to request a copy of any documents submitted to the insurer by the policyholder.

3.3. The insurer is obligated to:

3.3.1. Before concluding the insurance contract, inform the policyholder and/or the insured person of the terms of the contract;

3.3.2. Upon the request of the policyholder, issue a replacement policy and provide a copy of any documents submitted to the insurer by the policyholder;

3.3.3. Make a decision regarding the claim within one month of receiving all necessary documents;

3.3.4. In case of refusal to pay the insurance compensation, inform the insured person, their representative, or the beneficiary in a reproducible written format within 10 working days from the day the decision was made;

3.3.5. In the event of an insured event, pay compensation to the insured person, their representative, or the beneficiary within 10 working days from the date the decision was made;

3.3.6. In case of delay in payment, upon request from the person entitled to receive the compensation, pay interest in the amount specified in the Law of Obligations Act;

3.3.7. Ensure confidentiality when communicating with the policyholder and/or the insured person.

3.4. The insurer has the right for valid reasons (such as situations where another proceeding is underway regarding the same event, the outcome of which is crucial for making a decision, or if the decision-making is hindered due to circumstances caused by the insured person or the policyholder), to extend the deadline specified in clause 3.3.3 of these terms and conditions..

4. Insured event

An insured event is considered to be:

4.1. **Illness** – an unexpected health disorder, the initial symptoms of which appear after the insurance contract has been concluded while the insured person is in the insured area during the insurance period, and which requires urgent medical attention;

4.2. **Exacerbation of a chronic illness** – a previously diagnosed health condition, which leads to a sudden deterioration in the insured person's physical condition after the insurance contract has been concluded, while the insured person is in the insured area during the insurance period, and requires the insured person to receive urgent inpatient medical care;

4.3. **Accident** – an unexpected event caused by external factors beyond the insured person's control (such as bodily injury, heatstroke, frostbite, poisoning from gases or substances accidentally entering the body), which occurs while the insured person is in the insured area during the insurance period and results in a sudden deterioration of the insured person's physical condition;

4.4. **Death of the insured person** as a result of the events mentioned in clauses 4.1–4.3.

5. Insurance indemnity Procedure

5.1. Reasonable and unavoidable expenses incurred for the treatment of an insured event that occurred during the insured person's trip are reimbursed, as well as funeral expenses or the costs of transporting remains to Estonia in the event of the insured person's death. These expenses must not exceed the insured sum and must be incurred during the validity of the insurance contract and within 20 days after the contract's expiration, within the insurance region specified in the contract.

5.2. In these terms, reasonable and unavoidable expenses are considered to be costs for medical

services provided when the insured person's health condition suddenly worsens. In such a case, the lack of immediate medical assistance would endanger the insured person's life, cause severe bodily function disorders, or result in organ malfunction. Reimbursement covers the usual minimum costs for treating injuries or illnesses at a state-recognized medical institution (an institution licensed to provide medical services) in the area where the insured event occurred.

5.3. If the insured person dies during the insurance period, the insurer will reimburse the costs specified in clause 5.4.6.4 to the beneficiary. If no beneficiary is specified, the insurer will reimburse the costs to the person who actually incurred them.

5.4. In the event of an insured event, the following expenses are reimbursed:

5.4.1. Necessary outpatient medical care;

5.4.2. Necessary inpatient medical care during the insurance period, up to 30 days;

5.4.3. Necessary laboratory tests;

5.4.4. Necessary use of medical transport;

5.4.5. Medications prescribed by a doctor;

5.4.6. If noted in the policy, the following costs are reimbursed to the extent specified in the policy:

5.4.6.1. Necessary medical care for acute tooth inflammation;

5.4.6.2. Treatment of pregnancy complications during travel, if occurring within the first 20 weeks of pregnancy;

5.4.6.3. Emergency transportation of the insured person to Estonia, as prescribed by a doctor and with the insurer's prior consent;

5.4.6.4. Funeral expenses abroad or transportation costs for repatriation of remains to the home country in the event of the insured person's death;

5.4.6.5. Reasonable and necessary accommodation and transportation costs for an escort of the insured person in the event of an insured event;

5.4.6.6. Reasonable costs incurred abroad to replace a lost or damaged single travel document (passport).

5.5. Only the portion of the expenses that is not covered by another valid insurance contract, law, medical program, international agreement, or other legal act, compulsory insurance, or mandatory insurance will be reimbursed.

5.6. The insurer will reimburse the expenses mentioned in clause 5.4 either to the insured person, their representative, or the beneficiary.

5.6.1. To apply for reimbursement, the insured person, their representative, or the beneficiary must submit the following documents to the insurer as soon as possible:

5.6.1.1. A claim for reimbursement, providing detailed and complete information about the circumstances of the accident or illness, and the contact details (address, phone number) and bank account number of the insured person, their representative, or the beneficiary;

5.6.1.2. The insurance policy;

5.6.1.3. A medical record or other documents from medical institutions (licensed providers of medical services) proving the occurrence of the accident or illness, including the diagnosis, tests conducted, and treatment provided;

5.6.1.4. Medical expense invoices and proof of payment, showing the name of the insured person;

5.6.1.5. Transportation expense invoices and proof of payment;

5.6.1.6. Investigation reports, if necessary;

5.6.1.7. In case of the insured person's death, a death certificate, invoices for the services mentioned in clause 5.4.6.4, and proof of payment;

5.6.1.8. Any other documents related to the insured event as required by the insurer. 5.6.2. The documents mentioned in clauses 5.6.1.3–5.6.1.5 and 5.6.1.7 must contain the contact details and seal of the medical institution, the name and signature of the doctor or issuer of the document, the prices of the services, the currency used, and in the case of a pharmacy receipt, the names, quantities, prices of the medicines, and the currency. 5.6.3. The insured person must allow the insurer access to all medical records (including sensitive personal data) related to the insured event, thereby releasing the doctors from the obligation of professional secrecy in regard to the insured event. The insured person permits the insurer to collect relevant information from investigative authorities, the police, medical institutions, and to conduct a medical examination of the insured person if necessary.

5.7. Payments to medical institutions will be made if the insured person cannot pay for the services listed in clause 5.4 and the medical institution has submitted an invoice along with medical documentation confirming the occurrence of the insured event and any additional documents required by the insurer.

6. Exclusions & Refusal or Reduction of indemnity

6.1. An insured event is not considered to be, and the insurer has no obligation to compensate for, damage caused by the following:

6.1.1. Military events, terrorist acts, coups, civil unrest, strikes, or similar events (including actions by officials exercising public authority); nuclear energy or radioactivity; epidemics, natural disasters, pollution, or similar;

6.1.2. The insured person's use of alcohol, drugs, or toxic substances, including the occurrence of an insured risk while under the influence of these substances; the insured person's suicide or attempted suicide; the insured person's intentional actions, including participation in fights; gross negligence or illegal actions by the insured person;

6.1.3. The insured person's participation in competitive sports or training for such; the insured person's involvement in higher-risk sports such as mountaineering, rock climbing, aviation and parachuting, water and underwater sports, horseback riding and horse trekking, motor sports, combat sports, and extreme sports;
6.1.4. The insured person's engagement in winter sports outside marked trails in a winter sports center;
6.1.5. The insured person's participation in physical labor, including professional driving;
6.1.6. The insured person's mental disorder or illness, including depression, epileptic seizures, bipolar disorder, hysteria, or similar;
6.1.7. Oncological diseases;
6.1.8. AIDS or HIV virus;
6.1.9. Diabetes;
6.1.10. Kidney failure;
6.1.11. Failure to follow a prescribed treatment plan, including not taking prescribed medications for chronic diseases.
6.2. Insurance for the cases mentioned in clauses 6.1.3. and 6.1.5. is possible only under a special agreement, with an appropriate note made on the policy.
6.3. The following are also not considered insured events and are not eligible for compensation:
6.3.1. Services provided 20 days after the expiration of the insurance contract;
6.3.2. Diagnosis and treatment of chronic diseases (except for emergency first aid in the event of an exacerbation of a chronic illness);
6.3.3. Treatment of illnesses or accidents that began before the start of the insurance contract (except for exacerbation of a chronic disease as stated in clause 4.2);
6.3.4. Planned treatments;
6.3.5. Unscientific or non-medical treatment methods;
6.3.6. Eye treatment (except emergency medical care to the extent specified in clause 5.2);
6.3.7. Dental care (except treatment for acute tooth inflammation as specified in clause 5.4.6.1);
6.3.8. Treatment of sexually transmitted diseases;
6.3.9. Treatment of infertility and contraceptive methods;
6.3.10. Medical care related to pregnancy and childbirth (except as specified in clause 5.4.6.2);
6.3.11. Preventive check-ups, vaccinations, and immunizations;
6.3.12. Manufacture of prosthetics;
6.3.13. Cosmetic and plastic surgery;
6.3.14. Rehabilitation, services provided by sanatoriums, resorts, and similar institutions;
6.3.15. Additional comforts or luxuries.
6.4. The insurer may refuse to compensate or reduce compensation if:
6.4.1. The policyholder or the insured person has not fully paid the insurance premium before the start of the insurance period;
6.4.2. The policyholder and/or the insured person has provided incorrect or incomplete information regarding the circumstances affecting the insurance contract or insured event;
6.4.3. The insured person does not have a valid European Health Insurance Card or a replacement certificate throughout the insurance period (for contracts covering the European insurance region);
6.4.4. The insured event is not reported, making it impossible to ascertain the circumstances of the event;
6.4.5. The documents listed in clause 5.6.1. are not submitted, or if the submitted documents do not provide detailed information on the insured person's diagnosis and treatment;
6.4.6. The insured person knowingly exploited the travel insurance to avoid paying for treatment or similar expenses in their country of residence or work;
6.4.7. The insured person knowingly used unnecessary medical services or used services for longer than necessary for the treatment;
6.4.8. The claim is not submitted within 3 months of the insured event, and as a result, it is difficult to determine the circumstances of the event;
6.4.9. The insured person or policyholder does not allow the insurer to investigate the insured event as required by clause 5.6.3.
6.5. When deciding on refusal or reduction of compensation, the insurer takes into account the impact of the policyholder's or insured person's breach of obligations on the occurrence of the insured event and the extent of the damage, as well as the culpability of the breach.

7. Data processing

7.1. The responsible data processor for data disclosed in connection with the conclusion and execution of the insurance contract is the insurer.
7.2. By entering into the insurance contract, the policyholder and insured persons consent to third parties (e.g., medical institutions, police, etc.) disclosing medical data of the insured persons and other necessary information for investigating the insured event to the insurer.
7.3. By requesting an insurance quote and/or entering into an insurance contract, the policyholder consents to the insurer's right to process data. The insurer has the right to process the data of the policyholder and insured persons for assessing insurance risk, preparing, concluding, and executing the insurance contract, and determining the rights and obligations arising from the contract. The conditions for the processing of data by the insurer (Elama Kindlustus AS's personal data processing conditions) can be found on the insurer's website www.elama.ee.

7.4. The insurer may use the data obtained from the conclusion or execution of the insurance contract for the preparation, conclusion, and execution of future insurance contracts.
7.5. The insurer has the right to forward data related to the claim to the authorities responsible for handling the insured event.
7.6. The policyholder has the right to access their personal data processed by the insurer and to request the correction of incorrect data.

8. Reporting an Insured Event

8.1. In the event of an insured event, the insured person or policyholder must notify the insurer or the partner company specified in the policy as soon as possible, either personally or through a representative. The insurer can be notified via the website www.elama.ee, by email at kahjud@elama.ee, or by calling +372 6410436.
8.2. When reporting an insured event, the following information is recommended to be included:

- Description of the insured event (what happened?);
- Details of the insured person and the time and place of the insured event;
- Medical information of the insured person, epicrisis, or other relevant information if the insured person's health was affected, and these data can be provided to the insurer;
- Contact information for reaching the insured person;
- Documents supporting the insured event (e.g., medical invoices, medical history, etc.).

9. Special Provisions

9.1. The right of claim against the person responsible for the damage is transferred from the policyholder to the insurer to the extent of the compensation paid.
9.2. The insured person and/or policyholder is obligated to return the compensation to the insurer if circumstances excluding compensation are revealed after the damage has been compensated or if a third party has compensated for the damage.

10. Dispute Resolution

10.1. The policyholder has the right to turn to the Insurance Conciliation Body of the Estonian Insurance Association to resolve a dispute with the insurer (www.eksl.ee; Mustamäe tee 46 (A-block), 10621 Tallinn).
10.2. All disputes arising from the insurance contract, including those unresolved by the conciliation body, will be settled in court.
10.3. This insurance contract is governed by Estonian law.

11. Insurance Supervision

Insurance supervision is carried out by the Financial Supervision Authority, Sakala 4, Tallinn 15030.